Proposed Model for Integrating the Medicare and Medicaid Appeals Processes

Overview: We are proposing to integrate the Medicare and Medicaid appeals processes for Special Needs Plans (SNPs) that serve dual eligibles. Under the proposed approach described below, SNPs would simultaneously submit adverse reconsiderations for services that could be covered by either Medicare or Medicaid, to the CMS Independent Review Entity (IRE) and the State Fair Hearing (SFH). The shorter of the two programs' timeframes for filing requests and conducting reviews would apply to the IRE review and SFH.[1] One of our goals in integrating the appeals process is that plans will simultaneously apply coverage criteria from both programs at the organization determination level and first level of appeal, the plan reconsideration. Thus, we note that States cannot require plans to implement this integrated appeals model and also allow enrollees to bypass the plan reconsideration level and go directly to the SFH.[2] As described further below, in most cases, this means that SNPs must follow Medicare timeframes, which are generally shorter than those under Medicaid.

Process Flow:

I. Organization/Initial Determination –

Standard Requests – Consistent with Medicare and Medicaid, SNPs will have 14 calendar days to decide whether to provide the service requested (with a possible 14 day extension).

Expedited Requests – SNPs have 72 hours to issue a decision, consistent with Medicare requirements, which is the shorter of the two deadlines. (Medicaid allows plans up to three working days.)

If the SNP denies coverage for the service, it must provide the enrollee with a notice that is consistent with both the Medicare and Medicaid regulatory requirements contained in 42 C.F.R. parts 422.568 and 438.404. It is especially important for the SNP to emphasize that if one program determines that the service should be covered, the SNP will provide that service promptly**.** From the enrollee's perspective, a coverage denial by the other program will be moot. Thus, so long as the SNP provides a notice at the time of any unfavorable organization determination based on both Medicare and Medicaid criteria, it is permissible to not provide a notice when a service does not meet the Medicare criteria, but the SNP covers the service based on Medicaid criteria.

[1] States cannot allow plans to use this model in cases where a benefit could be covered under both programs, and an enrollee elects to continue receiving the benefit while the appeal is pending. Since the continuation of benefits is a right provided by Medicaid, the appeal would have to be processed using only the Medicaid appeals process.

[2] We estimate that roughly half of all States currently allow enrollees to bypass the plan reconsideration level.

Filing Timeframe for a Plan Level Appeal (Reconsideration) – Because SNPs that use this model will be conducting a single reconsideration, SNPs must ensure that they satisfy the Federal programs' filing deadline requirements. Medicare provides 60 days for an enrollee to file a reconsideration, while States may provide between 20 and 90 days for an enrollee to file a request for a SFH. Thus, SNPs must require enrollees to file a reconsideration within 60 days from the date of the notice of the organizational/initial determination.

II. Reconsideration/Plan appeal –

Standard Reconsiderations – SNPs that use this model must respond to standard reconsiderations within 30 days (plus a possible 14-day extension) to ensure consistency with both programs' requirements.

Expedited Reconsiderations – SNPs must respond to requests for expedited reconsiderations within 72 hours (plus a possible 14-day extension) to ensure consistency with both programs' requirements.

III. Plan Responsibilities Following Reconsideration –
When a SNP upholds its decision to deny a request for a service in whole or in part, it must immediately notify the enrollee in writing that it is forwarding the case file to both Medicare and Medicaid (SFH) and that both programs are reviewing the appeal. Simultaneous auto-forwarding to the IRE and the SFH is necessary to maintain an integrated appeals process. States will have to establish a separate requirement in their Medicaid contract with the SNP to require auto-forwarding to the SFH level, since current Medicaid regulations do not require this. In its reconsideration decision letter, the SNP should emphasize that the SFH may take longer to render a decision due to the differences in the regulatory decision-making timeframes (§431.244 requires the SFH to issue decisions within 90 days minus the time the plan took to issue its reconsideration, while §422.592 requires the IRE to issue decisions within 30 days).

IV. Subsequent Appeals –
If both the IRE and SFH decisions are unfavorable, an enrollee has additional appeal rights under both programs. Consistent with Medicare requirements, he or she may request an ALJ review within 60 days of receipt of the IRE's decision. Under the Medicaid program, if the State conducts reviews of SFH decisions, it may automatically review the adverse decision or allow enrollees to request State review of an unfavorable SFH decision. Where the State does not permit review of SFH decisions, enrollees may appeal the adverse decision to a Federal court.

Advantages to utilizing the integrated appeals process-

- This process gives enrollees two levels of review without having to understand and go through the complexities of filing simultaneous review requests with both programs.
- This process ensures that enrollees still get the benefit of having the SNP apply the broadest coverage criteria available under either program. Since Medicaid's coverage criteria are generally broader than those under Medicare, advocates are concerned that beneficiaries who choose the Medicare appeals process may be denied a service under Medicare's more narrow coverage rules that would have been approved under Medicaid. By the time the beneficiary

learns of the adverse determination under the Medicare process, it will be too late for him/her to appeal the service under Medicaid. This approach obviates these concerns.

- This process will allow CMS and States to gather more specific appeals data. In turn, CMS, States, and SNPs may be able to use these data to prospectively develop better risk-adjusted capitation rates.
- The integrated process removes any advantage of pursuing an 1115 waiver of Medicaid appeal rights because it eliminates the need to steer an enrollee to a particular appeals process.

Disadvantages to utilizing the integrated appeals process –

- This process would likely increase the administrative burden on plans since they would be responsible for simultaneous filings under both programs.
- Plans may express concerns about allowing the beneficiary to pursue two avenues for appeal, since this will increase the likelihood of the beneficiary prevailing under either program. Also, as noted above, the fact that Medicaid's coverage criteria are generally broader than those under Medicare increases the likelihood that the plan would have to cover the service under Medicaid, which typically pays a much lower capitation rate.
- Other than automatically providing two reviews, this does not enhance an enrollee's legal rights since they can already pursue appeals under both programs.

Remaining Issues

Notices for Exhaustion of Benefits:

If benefits expire under one program but continue under the other, the SNP is not required to notify the enrollee of this expiration. If the enrollee later decides to appeal a decision involving this benefit, the SNP will notify the enrollee at that time that he or she must appeal to the program that last provided the benefit (usually Medicaid).

Payment Reconciliation:

Regardless of the process (choosing a single appeals process or following an integrated process), unlike fee-for-service, nothing about this process should result in Medicaid, Medicare, and/or the SNP attempting to recover money from another party.

1) If an enrollee has no liability for a service (or received/will receive it), there is no right for the enrollee or any other entity to use the appeals process under Subpart M of Part 422. Thus, the payer of last resort cannot use the appeals processes to collect "its share" of the payment for services from the other program.

2) Both Medicare and Medicaid contracts with the SNP are risk-based. Consequently, the PM-PM capitation rate should already reflect the risk of losing an appeal on either side. Any prospective payment adjustments based on appeals data should be handled outside the claim appeals processes.